

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

04983

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal within 72 hours after death.

|  |  |   |  |   |   |  |   |       |  |  |  |  |
|--|--|---|--|---|---|--|---|-------|--|--|--|--|
| 1  |  |   | <b>4992</b>  |   |   |  |   |       |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Somerset</b><br>MARYLAND  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE Maryland<br>b. COUNTY Somerset |   |   |  |   |       |  |  |  |  |
|  |  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Marumsco</b>                              |   |   |  |   |       |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Marumsco</b>  |  |   | c. LENGTH OF STAY IN 1b<br><b>Lifetime</b>   |   |   |  |   |       |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>RFD, near Marion</b>  |  |   | d. STREET ADDRESS<br><b>RFD, near Marion</b>   |   |   |  |   |       |  |  |  |  |
| 3. NAME OF<br>DECEASED<br>(Type or print)<br><b>GEORGE</b>   |  |   | First  | Middle  | Last  | 4. DATE<br>OF<br>DEATH                                       | Month   | Day   | Year                                       |  |  |  |
|  |  |   |  | <b>OLLIE</b>  | <b>BRIDDELLE</b>                                | <b>April 24,</b>   |   |       | <b>19 58</b>                               |  |  |  |
| 5. SEX   |  | 6. COLOR OR RACE  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>  | 8. DATE OF BIRTH  | 9. AGE (in years<br>last birthday)              | 10. UNDER 1 YEAR   | 11. UNDER 24 HRS.   |       |  |  |  |  |
| Male   |  | White   | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | <b>June 27<br/>1874</b>   | 83 yrs.   | Months   | Days  | Hours | Min.                                       |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer</b>   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own farm</b>   |   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b> |   |       | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |  |  |  |
| 13. FATHER'S NAME<br><b>Jenkins Briddle</b>  |  |   |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Annie Howard</b> |  |   |       |  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)   |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |   | Address<br><b>Wallace Briddle, Marion, Md.</b>               |   |       |  |  |  |  |
| No   |  | None  |  | None  |   |  |   |       |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  |  |   |  |   |   |  |   |       |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>443X</b> <i>Apparent recurrence of</i><br>DUE TO <i>Heart attack &amp; arterio</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Sclerosis - Senility -</i><br>DUE TO (c)  |  |   |  |   |   |  |   |       |  |  |  |  |
| INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |   |   |  |   |       |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |   |  |   |   |  |   |       |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED?   |  | 19. WAS AUTOPSY PERFORMED?<br><b>No</b>   |  |   |   |  |   |       |  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II or both.)<br><b>William H. Coulbourne, M.D.</b> |  |   |   |  |   |       |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour<br>o. m.<br>p. m.   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                       |  | 20e. PLACE OF INJURY (Home, farm, office, etc., or city or town)<br><b>DEPUTY MEDICAL EXAMINER<br/>FOR SOMERSET COUNTY, MD.</b><br>(County) (State) |   |  |   |       |  |  |  |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |   |  |   |   |  |   |       |  |  |  |  |
| ACTUAL SIGNATURE <b>William H. Coulbourne, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>EXAMINER'S NAME (Type) <b>William H. Coulbourne, M. D.</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DATE SIGNED <b>Apr 26, 58</b>  |  |   |  |   |   |  |   |       |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>4-27-58</b>   |  | 22c. NAME OF CEMETERY OR CREMATORIUM<br><b>Rehobeth Baptist Cemetery</b>  |   |  | 22d. LOCATION (City, town, or county)<br><b>Rehobeth, Md.</b> |       |  |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Bradshaw &amp; Sons, Crisfield, Md.</b>   |  | ADDRESS   |  | 24a. REC'D BY REGISTRAR<br><b>APR 29 '58</b>  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Alv. Leach</b>               |       |  |  |  |  |

BUREAU X-2

APR 29 1958

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**4988 CERTIFICATE OF DEATH**

04984

Reg. Dist. No.

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Somerset</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crisfield</b>   |  | c. LENGTH OF STAY IN 1b<br><b>Lifetime</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>329 Chesapeake Ave.</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED<br>(Type or print)   | First<br><b>JOHN</b>   | Middle<br><b>HENRY</b>  | Last<br><b>CHARNICK</b>  |
| 4. DATE OF DEATH   | Month<br><b>April</b>  | Day<br><b>20</b>  | Year<br><b>1958</b>  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>                             | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Jan. 22, 1882</b>   |
| 9. AGE (In years last birthday) <b>76 yrs.</b>   | 10. IF UNDER 1 YEAR<br>Months <b>0</b>                       | 11. IF UNDER 24 HRS.<br>Days <b>0</b>   | 12. IF UNDER 24 HRS.<br>Hours <b>0</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>laborer</b>  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Seafood Industry</b> | 11. BIRTHPLACE (State or foreign country)<br><b>Crisfield, Md.</b>  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>   |
| 13. FATHER'S NAME<br><b>John H. Charnick</b>   | 14. MOTHER'S MAIDEN NAME<br><b>unknown</b>                   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  | 16. SOCIAL SECURITY NO.                                      | 17. INFORMANT<br><b>Elsie Mae Charnick--329 Chesapeake Ave.</b>   | Address<br><b>Crisfield, Md.</b>   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>332X</b>  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 mos</b>  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO<br><br>(c)<br>DUE TO   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>480X</b>  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Pneumonia following flu -</b>                            |  |
| 20c. TIME OF INJURY<br>Hour<br>a. m.<br>p. m.  | Month<br>19  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town)<br>(County)<br>(State) |
| 21. I certify that I attended the deceased from <b>April 19, 1958</b> to <b>April 20, 1958</b> that I last saw the deceased alive on <b>April 19, 1958</b> , and that death occurred at <b>5:30 AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state)<br><b>Main St.--Crisfield, Md.</b> DATE SIGNED<br><b>Sarah M. Peyton</b> |  |   |  |
| ACTUAL SIGNATURE<br><b>Sarah M. Peyton</b>   |  | DATE SIGNED<br><b>Apr 24 '58</b>  |  |
| PHYSICIAN'S NAME (Type)<br><b>Dr. Sarah M. Peyton, M. D.</b>   |  | Main St.--Crisfield, Md.  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>Apr. 23, 1958</b>                    | 22c. NAME OF CEMETERY OR CREMATORIUM<br><b>Sunnyridge Cemetery</b>  | 22d. LOCATION (City, town, or county)<br><b>Crisfield, Md.</b> (State)   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Bradshaw &amp; Sons--Crisfield, Md.</b>   |  | 24a. REC'D BY REGISTRAR<br><b>Apr 24 '58</b>  |  |
|  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Al. L. Smith</b>   |  |

CLASSIFICATION OF DOCUMENT

BUREAU V. S.

APR 24 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04985

## 4993 CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |                                  |  |   |  |  |  |   |  |                            |                             |
|---|----------------------------------|--|---|--|--|--|---|--|----------------------------|-----------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>SOMERSET</b>   |                                  | MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b> |  | b. COUNTY<br><b>SOMERSET</b>   |   |  |                            |                             |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CRISFIELD</b>  |                                  | c. LENGTH OF STAY IN lb<br><b>2 HRS.</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CRISFIELD</b>                 |  |  |   |  |                            |                             |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>EDW. W. MCCREADY MEMO. HOSP.</b>   |                                  | d. STREET ADDRESS<br><b>133 MAPLE AVENUE</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |  |  |   |  |                            |                             |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>INFANT FEMALE</b>  |                                  | First  | Middle                                    | Last   | 4. DATE OF DEATH<br><b>COLLINS</b>               | Month<br><b>APRIL</b>  | Day<br><b>20</b>                        | Year<br><b>1958</b>  |                            |                             |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>APRIL 20, 1958</b> |  | 9. AGE (In years lost birthday) yrs.<br><b>0</b> | 10. IF UNDER 1 YEAR<br>Months<br><b>0</b>  | 11. IF UNDER 24 HRS<br>Days<br><b>0</b> | Hours<br><b>0</b>  | Min.<br><b>0</b>           |                             |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |  |                            |                             |
| 13. FATHER'S NAME<br><b>ROBERT LEE COLLINS</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>MARY ELLEN SOMERS</b>   |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>                                      |  | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br><b>MARY COLLINS, 133 MAPLE AVE., MARYLAND</b> |                            | Address<br><b>CRISFIELD</b> |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>Premature birth (con.)</b>   |                                  | DUE TO<br><b>776x</b>  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>0 hrs.</b>  |  |  |   |  |                            |                             |
| Conditions, if any, which<br>give rise to immediate<br>cause (a), stating the under-<br>lying cause lost.<br>(b)<br>DUE TO<br>(c)   |                                  |  |   |  |  |  |   |  |                            |                             |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                  |  |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |                            |                             |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |  |  |  |   |  |                            |                             |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m.<br>p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/><br><b>at work</b>                      |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>CRISFIELD</b>                           |  | 20f. (City or town)<br><b>CRISFIELD</b>  |   | (County)<br><b>MARYLAND</b>                                    | (State)<br><b>MARYLAND</b> |                             |
| 21. I certify that I attended the deceased from <b>4/20</b> , 19 <b>58</b> , to <b>4-20</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>APRIL 20</b> , 19 <b>58</b> , and that death occurred at <b>9:00 AM</b> , from the causes and on the date stated above. |                                  |  |   |  |  | ADDRESS (Street, city or town, state)<br><b>CRISFIELD, MARYLAND</b>                    |   |  |                            | DATE SIGNED                 |
| ACTUAL SIGNATURE<br><b>Sarah M. Peyton</b>  |                                  | M.D.   |   |  |  |  |   |  |                            |                             |
| PHYSICIAN'S NAME (Type)<br><b>DR. SARAH M. PEYTON</b>   |                                  | CRISFIELD, MARYLAND  |   |  |  |  |   |  |                            |                             |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>Apr. 21, 1958</b>  |   | 22c. NAME OF CEMETERY OR CREMATORIUM<br><b>Crisfield Cemetery</b>  |  | 22d. LOCATION (City, town, or county)<br><b>CRISFIELD, MD.</b>                         |   | (State)  |                            |                             |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Bradshaw &amp; Sons—Crisfield, Md.</b>   |                                  | ADDRESS  |   | 24a. REC'D BY REGISTRAR<br>DATE<br><b>APR 24 '58</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Alv. couch</b>  |   |  |                            |                             |

BUREAU V. S.

APR 24 1969

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4994 CERTIFICATE OF DEATH

04986

Reg. Dist. No.

|  |  |   |   |   |   |   |                                      |
|--|--|---|---|---|---|---|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>SOMERSET</b>  |  | MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b>  |   | b. COUNTY<br><b>SOMERSET</b>  |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CRISFIELD</b>   |  | c. LENGTH OF STAY IN 1b<br><b>14 DAYS</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>X MARION STATION, MARYLAND</b> |   |   |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>EDW. W. MCCREADY MEMO. HOSP.</b>   |  |   |   | d. STREET ADDRESS<br><b>/</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                      |
| 3. NAME OF<br>DECEASED<br>(Type or print)  |  | First<br><b>ESTELLA</b>   | Middle  | Lost<br><b>COTTMAN</b>  | 4. DATE<br>OF<br>DEATH<br><b>APRIL</b>                | Month<br><b>12</b>  | Day<br>Year<br><b>19 58</b>          |
| 5. SEX<br><b>FEMALE</b>  |  | 6. COLOR OR RACE<br><b>NEGRO</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Nov. 17, 1892</b>  | 9. AGE (In years<br>lost, birthday)<br><b>65 yrs.</b> | IF UNDER 1 YEAR<br>Months<br><b>0</b>   | IF UNDER 24 HRS.<br>Days<br><b>0</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housework</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                      |
| 13. FATHER'S NAME<br><b>Albie Ward</b>   |  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Leah Jane Whittington</b>  |   | Address   |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No.</b>   |  | 16. SOCIAL SECURITY NO.<br><b>217-30-7502</b>   |   | 17. INFORMANT<br><b>OSCAR COTTMAN, MARION STATION, MD.</b>  |   |   |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>422.2</b><br>DUE TO<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause last. }<br>(b) DUE TO<br>(c) |  | <b>Uremia. Acute Delirium</b>   |   |   |   | INTERVAL BETWEEN<br>ONSET AND DEATH<br><b>2 weeks</b>   |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |   |   |   |   | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |   |   |   |   |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m.      p. m.<br>19  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |                                      |
| 21. I certify that I attended the deceased from <b>3/28</b> , 19 <b>58</b> , to <b>4/12</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>APRIL 12</b> , 19 <b>58</b> , and that death occurred at <b>1:30 P.M.</b> , from the causes and on the date stated above.                |  |   |   |   |   | ADDRESS (Street, city or town, state)   |                                      |
| ACTUAL<br>SIGNATURE<br><b>George Coulbourn M.D.</b>  |  |   |   |   |   | DATE SIGNED<br><b>4/12/58</b>   |                                      |
| PHYSICIAN'S<br>NAME (Type)<br><b>GEORGE C. COULBOURN</b>   |  |   |   | MARION STATION, MARYLAND  |   |   |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>4/16/58</b>   |   | 22c. NAME OF CEMETERY OR CREMATORIUM<br><b>Mt. Peer</b>   |   | 22d. LOCATION (City, town, or county)<br><b>Marion Sta., Soos Co., Md.</b>                        |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles H. Ward - Marion Sta., Md.</b>  |  | ADDRESS   |   | 24a. REC'D BY REGISTRAR<br>DATE<br><b>APR 21 '58</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><b>W. L. French</b>   |                                      |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF MAIL - BOSTON 1958



1958

1958 - 1959 WPA

1958 - 1959

1958-59

1958

BUREAU Y.

APR 21 1958

RECEIVED

1958 - 1959 WPA

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4995

## CERTIFICATE OF DEATH

Reg. Dist. No.

04987

|   |                                  |   |   |  |   |   |                   |                  |  |  |
|---|----------------------------------|---|---|--|---|---|-------------------|------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Somerset</b>   |                                  | MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> |   | b. COUNTY<br><b>Somerset</b>  |                   |                  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crisfield</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>35 years</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crisfield</b>                 |   |   |                   |                  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>R. F. D. #1</b>  |                                  |   |   | d. STREET ADDRESS<br><b>R. F. D. #1</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                   |                  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>VENNIA</b>   |                                  | First<br><b>VENNIA</b>  | Middle<br><b>M.</b>                           | Lost<br><b>HOWARD</b>  | 4. DATE OF DEATH<br><b>April 29,</b>      | Month<br><b>1958</b>  | Day               | Year             |  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><b>WIDOWED</b>              | 8. DATE OF BIRTH<br><b>September 28, 1890</b> | 9. AGE (In years<br>last birthday)<br><b>67</b>  | 10. IF UNDER 1 YEAR<br>Months<br><b>6</b> | 11. IF UNDER 24 HRS.<br>Days<br><b>0</b>  | Hours<br><b>0</b> | Min.<br><b>0</b> |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Processor</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Canning</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>New Church, Virginia</b>   |   | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>   |                   |                  |  |  |
| 13. FATHER'S NAME<br><b>Julius Mason</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>    |  |   |   |                   |                  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>216-05-8899</b>   |   | 17. INFORMANT<br><b>Mrs. Clinton White, Crisfield, Md.</b>   |   | Address   |                   |                  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Breathing困难, Terminal</i><br>DUE TO<br><b>442X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Emaciation</i><br>DUE TO<br>(c) <i>Hypertension Cardi-Vascular-Renal Disease</i><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>6 days</b> |                                  |   |   |  |   |   |                   |                  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>1491X</b><br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                  |   |   |  |   |   |                   |                  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |   |  |   |   |                   |                  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m.      p. m.      19   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town)   |                   | (County)         | (State)  |  |
| 21. I certify that I attended the deceased from <b>May 15, 1958</b> , to <b>April 29, 1958</b> , that I last saw the deceased alive on <b>April 29, 1958</b> , and that death occurred at <b>11:45 P.M.</b> , from the causes and on the date stated above.   |                                  | ADDRESS (Street, city or town, state)<br><b>Cumtoll, Md.</b>  |   |  |   |   |                   |                  | DATE SIGNED<br><b>4/30/58</b>                        |  |
| ACTUAL SIGNATURE<br><b>A. N. Barr, M.D.</b>   |                                  |   |   |  |   |   |                   |                  |  |  |
| PHYSICIAN'S NAME (Type)<br><b>A. N. Barr, M.D.</b>  |                                  | Crisfield, Md.  |   |  |   |   |                   |                  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>May 2, 1958</b>   |   | 22c. NAME OF CEMETERY OR CREMATORIUM<br><b>Nelson Cemetery</b>   |   | 22d. LOCATION (City, town, or county)<br><b>Pocomoke, Md.</b>                                     |                   | (State)          |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Bradshaw &amp; Sons, Crisfield, Md.</b>  |                                  | ADDRESS<br><b>Bradshaw &amp; Sons, Crisfield, Md.</b>   |   |  |   |   |                   |                  | 24a. REC'D. BY REGISTRAR<br>DATE<br><b>MAY 5 '58</b> |  |
|   |                                  |   |   |  |   |   |                   |                  | 24b. REGISTRAR'S SIGNATURE<br><b>W. L. Gedrich</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04988

## 4996 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>b. STATE<br>c. COUNTY  |   |
| <i>Somerset,<br/>Maryland</i>   |  | <i>Maryland Somerset,</i>   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |  | c. LENGTH OF STAY IN lb<br><i>at Home</i>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |  | d. STREET ADDRESS<br><i>Main Road</i>   |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |   |
| 3. NAME OF DECEASED<br>(Type or print)  |  | First<br><i>JOHN</i>  | Middle<br><i>H.</i>   |
| Last<br><i>JOHNSON</i>  |  | 4. DATE OF DEATH<br>Month<br><i>April</i>   | Day<br><i>9</i>   |
| 5. SEX<br><i>Male Negro</i>   |  | 6. COLOR OR RACE<br>WIDOWED <input checked="" type="checkbox"/>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH<br><i>3-4-1887</i>   |  | 9. AGE (in years<br>old birthday)<br><i>91 yrs</i>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Retired Waterman Seafood</i>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Maryland</i>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><i>U. S.</i>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U. S.</i>  |   |
| 13. FATHER'S NAME<br><i>JOHN JOHNSON</i>  |  | 14. MOTHER'S MAIDEN NAME<br><i>MARY JOHNSON</i>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><i>No</i>  |  | 16. SOCIAL SECURITY NO.<br><i>220-10-9742</i>   |   |
| 17. MIGRATION<br>Address<br><i>oland Johnson - Nanticoke Md.</i>  |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><i>Congestive Heart Failure</i><br>DUE TO<br><i>443X</i><br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the underlying cause last.<br>(b)<br>DUE TO<br><i>Generalized arteriosclerosis</i><br>(c) |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | INTERVAL BETWEEN<br>ONSET AND DEATH<br><i>years</i>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><i>Hypertensive cardiovascular disease, arthritis</i>   |   |
| 20c. TIME OF INJURY<br>Hour<br>a. m.<br>p. m.<br>19   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town)<br>(County)<br>(State)  |   |
| 21. I certify that I attended the deceased from <i>9-15-58</i> , 19, to <i>4-9-58</i> , 19, that I last saw the deceased alive on <i>4-6-58</i> , 19, and that death occurred at <i>7:15P</i> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state)<br><i>Danes Quarter, Maryland</i> DATE SIGNED<br><i>4-12-58</i> |  |   |   |
| ACTUAL SIGNATURE<br><i>Everett C. Sutter</i> M.D.   |  |   |   |
| PHYSICIAN'S NAME (Type)<br><i>Everett C. Sutter MD</i>  |  | 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial 4-13-58</i>  |   |
| 22b. DATE THEREOF<br><i>4-13-58</i>   |  | 22c. NAME OF CEMETERY OR Crematory<br><i>John Wesley</i>  |   |
| 22d. LOCATION (City, town, or county)<br><i>Deale Island Rd.</i>  |  | 22e. SIGNATURE (Sign)   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>Everett Sutter Nanticoke Md.</i>   |  | 24a. REC'D BY REGISTRAR<br>DATE<br><i>APR 16 '58</i>  |   |
| ADDRESS<br><i>Nanticoke</i>   |  | 24b. REGISTRAR'S SIGNATURE<br><i>Aut. Search</i>  |   |

RECEIVED  
BUREAU V. S.

APR 16 1959

1

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

04989

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form M3. Page 5 may be retained by your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |  |  |   |  |   |
|--|--|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 4989   |   | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)                                  |   |
| Somerset   |  | MARYLAND   |   | a. STATE Maryland b. COUNTY Somerset   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |  | c. LENGTH OF STAY IN TB  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)                                     |   |
| Crisfield  |  | 62 years   |   | Crisfield  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)   |  | d. STREET ADDRESS  |   | e. IS RESPONDEE ON A FARM<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |   |
| 947 W. Broad St.   |  | 947 W. Broad St.   |   | f. DATE OF DEATH Month Day Year<br>April 15, 1958  |   |
| 3. NAME OF DECEASED<br>(Type or print)   |  | First  | Middle  | Lost   | Month Day Year                            |
|  |  | NELLIE   | SCARBOROUGH   | JONES  | 19 58                                     |
| 4. SEX   |  | 6. COLOR OR RACE   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                                | 8. DATE OF BIRTH   | 9. AGE (In years last birthday)<br>67 yrs |
| Female   |  | Negro  | WIDOWED <input checked="" type="checkbox"/>   | March 10, 1891   | IF UNDER 1 YEAR<br>Months Days Hours Min  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)  |   |
| Seaford Worker   |  | Oyster & Crab  |   | Accomac, Virginia  |   |
| 12. CITIZEN OF WHAT COUNTRY?   |  |  |   | USA  |   |
| 13. FATHER'S NAME  |  | 14. MOTHER'S MAIDEN NAME   |   | Address  |   |
| Ned Sterling   |  | Martha Scarborough   |   | Md.  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO   |   | 17. INFORMANT  |   |
| No None  |  | 212-12-3366  |   | Wm. H. Jones, Jr. 947 W. Broad St., Crisfield,   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | INTERVAL BETWEEN ONSET AND DEATH   |   |  |   |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)  |  | DUE TO   |   |  |   |
| 434.2  |  | Asthma   |   |  |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  | (b)  |   |  |   |
|  |  | Cardiac complication   |   |  |   |
| DUE TO   |  | Complication   |   |  |   |
| (c)  |  | Coulbourn, M. D.   |   |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  | DEPUTY MEDICAL EXAMINER FOR SOMERSET COUNTY, MD.   |   |  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II)  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                               |   |
| 20c. TIME OF INJURY<br>Hour a. m. p. m.  |  | Month, Day, Year<br>19   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town)<br>(County)<br>(State) |   |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |   |  |   |
| ACTUAL SIGNATURE<br><i>William H. Coulbourn</i>  |  | DATE SIGNED<br><i>Apr 17/58</i>  |   |  |   |
| EXAMINER'S NAME (Type) William H. Coulbourn, M. D.   |  | 22b. DATE THEREOF<br>4-18-58   |   | 22c. NAME OF CEMETERY OR CREMATORIUM<br>Lawsonia Cemetery  |   |
| 22d. LOCATION (City, town, or county)<br>Crisfield, Md.  |  | (State)  |   |  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>Bradshaw & Sons, Crisfield, Md.  |  | ADDRESS  |   | 24a. REC'D BY REGISTRAR<br>DATE  |   |
|  |  |  |   | 24b. REGISTRAR'S SIGNATURE<br><i>W. H. Coulbourn</i>   |   |

BUREAU Y.  
S. G. E. I. V. E. D.

1958

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04990

## 4997 CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                               |   |   |
|--|-------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Somerset</u>   |                               | 2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission]<br>a. STATE <u>Md</u>     |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Westover</u>  | c. LENGTH OF STAY IN lb       | b. COUNTY <u>Somerset</u>   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Westover</u> |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   | d. STREET ADDRESS             |   |   |
| II. NAME OF DECEASED First <u>Arintha</u> Middle <u>B.</u> Last <u>Miles</u>   |                               | 4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1958</u>  |   |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>Nigro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                           | 8. DATE OF BIRTH June 18, 1899  |
|  |                               | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 9. AGE (In years last birthday) yrs <u>38</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Factory Laborer</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Baltimore</u>  |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |   |
| 13. FATHER'S NAME <u>John Milbourne</u>  |                               | 14. MOTHER'S MAIDEN NAME <u>Mary Hester Ballard</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>No</u><br>(Yes, no or unknown) (If yes, give war or date of service)   |                               | 16. SOCIAL SECURITY NO. <u>219-0338-29</u>  |   |
| 17. INFORMANT <u>Arintha P. Miles</u>  |                               | Address <u>Westover, Md.</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  |                               | INTERVAL BETWEEN ONSET AND DEATH  |   |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)<br><br><u>443X</u>   |                               | <u>Cerebral Hemorrhage</u> <u>1 hr</u>  |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.<br>(b)   |                               | <u>Hypertension</u> <u>2 yrs</u>  |   |
| DUE TO<br><br><u>443X</u>  |                               | <u>Cardio Vascular Disease</u> <u>3 yr</u>  |   |
| (c)  |                               |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)<br><br><u>Arthritis</u>  |                               | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><br><u>none</u> |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. <u>19</u><br>p. m.  |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>       |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) <u>—</u><br>(County) <u>—</u><br>(State) <u>—</u>   |   |
| 21. I certify that I attended the deceased from <u>Apr. 4</u> , 1958, to <u>Apr. 25</u> , 1958, that I last saw the deceased alive on <u>Apr. 25</u> , 1958, and that death occurred at <u>5:10 AM</u> , from the causes and on the date stated above. |                               | ADDRESS (Street, city or town, State) <u>20 Prince William St., Bayside, Md.</u> DATE SIGNED <u>4/27/58</u>     |   |
| ACTUAL SIGNATURE <u>B. Frank Giganti</u>   |                               | PHYSICIAN'S NAME (Type) <u>B. FRANK GIGANTI</u>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                               | 22b. DATE THEREOF <u>May 1, 1958</u>  |   |
| 22c. NAME OF CEMETERY OR CREMATORIUM <u>Cottage Grove</u>  |                               | 22d. LOCATION (City, town, or county) <u>Cottage Grove, Md.</u> (State) <u>—</u>                                |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward Marion Sta., Md.</u>   |                               | ADDRESS <u>—</u>  |   |
| 24a. REC'D BY REGISTRAR <u>MAY 5 '58</u>   |                               | 24b. REGISTRAR'S SIGNATURE <u>W. W. French</u>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be re-used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

04991

Reg. Dist. No.

|  |                                   |  |  |
|--|-----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY SOMERSET  |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE MARYLAND |  |
|  |                                   | b. COUNTY SOMERSET   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>POCOPONTE I. | c. LENGTH OF STAY IN lb<br>7 DAYS | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>POCOPONTE I.           |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)                     |                                   | d. STREET ADDRESS  |  |

|  |            |        |              |  |
|--|------------|--------|--------------|--|
| 3. NAME OF DECEASED<br>(Type or print) | First BABY | Middle | Last PITTMAN | 4. DATE OF DEATH<br>Month 4 Day 25 Year 1958 |
|--|------------|--------|--------------|--|

|               |                          |  |                            |  |                                |                                |
|---------------|--------------------------|--|----------------------------|--|--------------------------------|--------------------------------|
| 5. SEX FEMALE | 6. COLOR OR RACE COLORED | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>4/1/58 | 9. AGE (In years last birthday)<br>yrs. Months Days Hours Min. | IF UNDER 1 YEAR<br>Months Days | IF UNDER 24 HRS.<br>Hours Min. |
|---------------|--------------------------|--|----------------------------|--|--------------------------------|--------------------------------|

|   |                                   |   |  |
|---|-----------------------------------|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)<br>MARYLAND | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A. |
|---|-----------------------------------|---|--|

|                                    |   |
|------------------------------------|---|
| 13. FATHER'S NAME<br>JESSE COLLIER | 14. MOTHER'S MAIDEN NAME<br>HELEN PITTMAN |
|------------------------------------|---|

|  |                         |               |         |
|--|-------------------------|---------------|---------|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>(If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|--|-------------------------|---------------|---------|

|  |   |  |  |   |
|--|---|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  | PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) DUE TO (b) <u>Bronch pneumonia</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (c) <u>sick for two days with cold and fever</u> |  | INTERVAL BETWEEN SET AND DEATH<br>2 days |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

|   |  |  |                     |          |         |
|---|--|--|---------------------|----------|---------|
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)           |  |                     |          |         |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |  |  |  |  |  |
|---|--|--|--|--|--|

|                                      |                                     |
|--------------------------------------|-------------------------------------|
| ACTUAL SIGNATURE <u>R.H. Johnson</u> | DATE SIGNED<br><u>April 26-1958</u> |
|--------------------------------------|-------------------------------------|

|   |  |
|---|--|
| EXAMINER'S NAME (Type) <u>R. H. Johnson</u> | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> |
|   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |
|   | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>     |

|   |                              |   |   |
|---|------------------------------|---|---|
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL | 22b. DATE THEREOF<br>4/26/58 | 22c. NAME OF CEMETERY OR CREMATORIUM<br>TINDBLEY CHAPEL | 22d. LOCATION (City, town, or county)<br>TINDBLEY, MARYLAND (State) |
|---|------------------------------|---|---|

|  |         |                                       |  |
|--|---------|---------------------------------------|--|
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>WILLIAM H. JONES, JR., PRINCESS ANNE, MD | ADDRESS | 24a. REC'D BY REGISTRAR<br>MAY 2 1958 | 24b. REGISTRAR'S SIGNATURE<br><u>Alfred E. Ede</u> |
|--|---------|---------------------------------------|--|

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same in pencil, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for you.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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and time spent at schools  
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4990 CERTIFICATE OF DEATH

04992

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician and completely filled in by the funeral director.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Somerset</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE <b>MARYLAND</b>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crisfield</b>   |                                  | c. LENGTH OF STAY IN lb<br><b>Lifetime</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>East Chesapeake Ave.</b>   |                                  | e. IS RESIDENCE<br>ON A FARM<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF<br>DECEASED<br>(Type or print)<br><b>CLEVELAND</b>  |                                  | First                          Middle                          Last<br>—                          — <b>SOMERS</b>   | 4. DATE<br>OF<br>DEATH<br><b>April 25, 1958</b>  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>August 18, 1884</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><b>waterman</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Seafood</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |
| 13. FATHER'S NAME<br><b>Hance Somers</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Matilda Sterling</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO<br><b>215-10-2771</b>  | 17. INFORMANT<br><b>Mrs. Esther Somers, Crisfield, Md.</b>   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>Part I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>331X</b>  |                                  | INTERVAL BETWEEN<br>ONSET AND DEATH<br><b>5-6 hrs</b>   |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause first.<br>(b)  |                                  | DUE TO<br><b>Cerebral hemorrhage</b>  |  |
| (c)  |                                  | DUE TO<br><b>arterio sclerosis</b>  |  |
| Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                  | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour      o. m.      p. m.<br>19   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town)<br>(County)      (State) |
| 21. I certify that I attended the deceased from <b>July 9, 1954</b> , to <b>April 25, 1958</b> , that I last saw the deceased<br>alive on <b>April 25, 1958</b> , and that death occurred at <b>Crisfield, Md.</b> |                                  | ADDRESS (Street, city or town, state)<br><b>Crisfield, Md.</b>  |  |
| ACTUAL<br>SIGNATURE<br><br><i>C. G. Rawley</i>   |                                  | DATE SIGNED<br><b>APR 29 '58</b>  |  |
| PHYSICIAN'S<br>NAME (Type)<br><b>C. G. Rawley, M. D.</b>   |                                  | Crisfield, Md.  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>4-27-58</b>   | 22c. NAME OF CEMETERY OR CREMATORIUM<br><b>Sunnyridge Cemetery</b>   |
| 22d. LOCATION (City, town, or county)<br><b>Crisfield, Md.</b>   |                                  | (State)   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><br><i>Bradshaw &amp; Sons, 531 Main St., Crisfield, Md.</i>   |                                  | 24a. REC'D BY REGISTRAR<br>DATE<br><b>APR 29 '58</b>  | 24b. REGISTRAR'S SIGNATURE<br><i>John J. Deane</i>   |

BUREAU V. S.

APR 29 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item #14 Film G229 5/23/58 mb

04993

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE         |  |
| <del>Somerset</del><br>on<br>Rural Crossfield  |  | Md<br>Somerset  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |  | c. LENGTH OF STAY IN 1b<br>LIFE   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |  | e. STREET ADDRESS<br>Rural Crossfield   |  |
| 3. NAME OF DECEASED (Type or print)  |  | First   | Middle   |
| Eugene Edward Sterling   |  |   |  |
| 4. DATE OF DEATH   |  | Month   | Day  |
| April  |  | 7   | 1958   |
| 5. SEX   |  | 6. COLOR OR RACE  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| Male   |  | White   | BORN JUN 1882  |
| 8. DATE OF BIRTH   |  | 9. AGE (In years last birthday)   | 10. IF UNDER 1 YEAR<br>Months Days   |
|  |  | 76 yrs.   | IF UNDER 24 HRS<br>Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (State or foreign country)  |
| Retired Farmer   |  |   | Md   |
| 12. CITIZEN OF WHAT COUNTRY?   |  | U.S.  |  |
| 13. FATHER'S NAME  |  | 14. MOTHER'S MAIDEN NAME  |  |
| Robert Sterling  |  | Lucy Bradshaw   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown, III yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO.   |  |
| No   |  | 17. INFORMANT   |  |
| Newman Sterling Crossfield Md  |  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART I. DEATH WAS CAUSED BY:<br>(IMMEDIATE CAUSE (a))  |  | 7-8 days  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br><br>(b)  |  | DUE TO  |  |
| (c)  |  | DUE TO  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                    |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. 19 p. m.  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>Sayat</u> , 1957, to <u>April 7</u> , 1958, that I last saw the deceased alive on <u>April 7</u> , 1958, and that death occurred at <u>12:30 A.M.</u> from the causes and on the date stated above. |  | ADDRESS (Street, city or town, state)   |  |
| ACTUAL SIGNATURE <u>C. R. Crowley</u> M.D.   |  | DATE SIGNED <u>4/8/58</u>   |  |
| PHYSICIAN'S NAME (Type)  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>  |  | 22b. DATE THEREOF <u>4/8/58</u>   |  |
| 22c. NAME OF CEMETERY OR CREMATORIAL <u>Sunnyvale</u>  |  | 22d. LOCATION (City, town, or county) <u>Crossfield</u> (State) <u>Md</u>                                 |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS <u>James Newman Crossfield Md.</u>   |  | 24a. REC'D BY REGISTRAR DATE <u>APR 14 1958</u> 24b. REGISTRAR'S SIGNATURE <u>Alb. Smith</u>              |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be referred to by the hospital or attending physician  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 32 should be filed with the funeral director.

CUREAU Y.

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LEADER

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04994

5000

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |   |  |  |  |   |                         |                               |                            |
|---|----------------------------------|---|--|--|--|---|-------------------------|-------------------------------|----------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>SOMERSET</b>   |                                  | MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b> |  | b. COUNTY<br><b>SOMERSET</b>  |                         |                               |                            |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>GRTSFELD</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>CRISFIELD</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CRISFIELD</b>                 |  | d. STREET ADDRESS<br><b>946 WEST BROAD STREET</b>   |                         |                               |                            |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>EDW. W. MCCREADY MEMO.</b>  |                                  |   |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                         |                               |                            |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>EMMA</b>   |                                  | First   | Middle   | Last   | 4. DATE OF DEATH<br><b>APRIL</b>                 | Month   | Day<br><b>18</b>        | Year<br><b>1958</b>           |                            |
| 5 SEX<br><b>FEMALE</b>  | 6. COLOR OR RACE<br><b>NEGRO</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                     | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>JULY 10, 1891</b>   | 9. AGE (In years last birthday)<br><b>66 yrs</b> | IF UNDER 1 YEAR<br>Months   | IF UNDER 24 HRS<br>Days | Hours Min                     |                            |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>  |                                  | 10b KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>VIRGINIA</b>   |  | 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                         |                               |                            |
| 13. FATHER'S NAME<br><b>JAMES MAPP</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>MISSOURI ?</b>   |  |  |  |   |                         |                               |                            |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>   |                                  | 16. SOCIAL SECURITY NO  |  | 17. INFORMANT<br><b>MARY BROWN, 945 BROAD St., CRISFIELD</b>   |  | Address   |                         |                               |                            |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)].<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>420.0</b><br>DUE TO<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause last.<br>(b)<br>DUE TO<br>(c) |                                  | Cerebral Hemorrhage   |  | Cerebrovascular Hemorrhage, Hypertension, etc.   |  | INTERVAL BETWEEN<br>ONSET AND DEATH<br><b>6 days</b>  |                         |                               |                            |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>48IX Influenza</b>   |                                  |   |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |                         |                               |                            |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |  |  |   |                         |                               |                            |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m.<br>p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town)<br><b>CRISFIELD</b>   |                         | (County)<br><b>MARYLAND</b>   | (State)<br><b>MARYLAND</b> |
| 21. I certify that I attended the deceased from <b>March 3, 1951, to April 18, 1958</b> , that I last saw the deceased alive on <b>April 17, 1957</b> , and that death occurred at <b>5:40 AM</b> , from the causes and on the date stated above.   |                                  |   |  |  |  | ADDRESS (Street, city or town, state)<br><b>CRISFIELD, MARYLAND</b>                               |                         | DATE SIGNED<br><b>4/18/58</b> |                            |
| ACTUAL SIGNATURE<br><b>A. N. Barr</b>   |                                  | M.D.  |  |  |  |   |                         |                               |                            |
| PHYSICIAN'S NAME (Type)<br><b>DR. A. N. BARR</b>  |                                  |   |  |  |  |   |                         |                               |                            |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>Apr. 21, 1958</b>   |  | 22c. NAME OF CEMETERY OR CREMATORIUM<br><b>Burton Cemetery</b>   |  | 22d. LOCATION (City, town, or county)<br><b>Watchapreague, Virginia</b>                           |                         | (State)                       |                            |
| 23 FUNERAL DIRECTOR'S SIGNATURE<br><b>Bradshaw &amp; Sons--Grisfield, Md.</b>   |                                  | ADDRESS   |  | 24a. REC'D BY REGISTRAR<br><b>APR 22 '58</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Q. F. Smith</b>  |                         |                               |                            |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

55 3 1960

REGISTRE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5001

## CERTIFICATE OF DEATH

04995

Reg. Dist. No.

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>SOMERSET</b>  |  | MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE<br><b>MARYLAND</b> |  | b. COUNTY<br><b>SOMERSET</b>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CRISFIELD</b>   |  | c. LENGTH OF STAY IN lb<br><b>45 years</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>39 CRISFIELD</b>              |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>EDW. W. McCREADY MEMORIAL HOSP.</b>   |  | d. STREET ADDRESS<br><b>SOMERSET</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>First M. Middle BREVORT Last THAWLEY</b>  |  | 4. DATE OF DEATH<br><b>APRIL 4 1958</b>  |  | Month  |  | Day Year  |  |
| 5. SEX<br><b>MALE</b>  |  | 6. COLOR OR RACE<br><b>WHITE</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                                |  | 8. DATE OF BIRTH<br><b>9-7-1884</b>   |  |
|  |  |  |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. AGE (In years<br>(put birthday)<br><b>73 yrs.</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>OWNER</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>LUMBER Co.</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>John W. Thawley</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Adelaide Cochrane</b>   |  |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO<br><b>None</b>  |  | 17. INFORMANT<br><b>MRS. ALICE THAWLEY, CRISFIELD, Md.</b>   |  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>Uremia acit dil of heart</b>  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b>   |  |
| DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO<br><b>Cirrhosis &amp; heart insufficiency in brain</b>   |  |  |  |  |  |   |  |
| (c)  |  |  |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)  |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)<br><b>By falls, etc. in my bed of home</b> |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m.<br>p. m.<br><b>19</b>   |  | 20d. INJURY OCCURRED<br>While Not while<br>of work <input type="checkbox"/> at work <input type="checkbox"/>                           |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>—</b>                                   |  | 20f. (City or town) (County) (State)<br><b>—</b>  |  |
| 21. I certify that I attended the deceased from <b>March 30, 1958</b> , to <b>April 4, 1958</b> , that I last saw the deceased alive on <b>APRIL 4, 1958</b> , and that death occurred at <b>3:00 P.M.</b> from the causes and on the date stated above. |  |  |  |  |  | ADDRESS (Street, city or town, state)<br><b>MARION STATION, MD.</b>                               |  |
| ACTUAL SIGNATURE<br><b>George C. Coulbourn</b>   |  |  |  |  |  | DATE SIGNED<br><b>—</b>   |  |
| PHYSICIAN'S NAME (Type)<br><b>DR. GEORGE C. COULBOURN</b>  |  |  |  |  |  | MARION STATION, MARYLAND  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>4-8-58</b>   |  | 22c. NAME OF CEMETERY OR CREMATORIUM<br><b>Sunnyridge Cemetery</b>   |  | 22d. LOCATION (City, town, or county)<br><b>Crisfield, Maryland</b>                               |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Bradshaw &amp; Sons, Crisfield, Maryland</b>  |  | ADDRESS  |  | 24a. REC'D BY REGISTRAR<br><b>SPR 8 '58</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Al Sechrist</b>  |  |

**HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Loge may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1923

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04996

5102

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                  |  |                  |   |                 |                                       |            |
|---|------------------|--|------------------|---|-----------------|---------------------------------------|------------|
| 1. PLACE OF DEATH<br>a. COUNTY  |                  | MARYLAND   |                  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE |                 | Maryland                              |            |
| SOMERSET  |                  |  |                  | b. COUNTY   |                 | Somerset.                             |            |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |                  | c. LENGTH OF STAY IN 1b  |                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)                  |                 |                                       |            |
| WENONA  |                  | LIFE   |                  | Wenona  |                 |                                       |            |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                  | e. STREET ADDRESS  |                  | f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |                 |                                       |            |
| AT HOME   |                  | Main Road  |                  |   |                 |                                       |            |
| 3. NAME OF DECEASED<br>(Type or print)  | First            | Middle   | Last             | 4. DATE OF DEATH  | Month           | Day                                   | Year       |
| MARY  |                  |  | THOMAS           | April   | 3               |                                       | 1958       |
| 5. SEX  | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years lost birthday)   | IF UNDER 1 YEAR | IF UNDER 24 HRS                       |            |
| Female  | White            |  | April 1879       | 75 yrs.   | Months          | Days                                  | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                  | 10b. KIND OF BUSINESS OR INDUSTRY  |                  | 11. BIRTHPLACE (State or foreign country)   |                 | 12. CITIZEN OF WHAT COUNTRY?          |            |
| Household duties Household  |                  |  |                  | Maryland  |                 | U.S.A.                                |            |
| 13. FATHER'S NAME   |                  | 14. MOTHER'S MAIDEN NAME   |                  |   |                 |                                       |            |
| CYRUS   |                  | MARY   |                  |   |                 |                                       |            |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)  |                  | 16. SOCIAL SECURITY NO.  |                  | 17. INFORMANT   |                 | Address                               |            |
| no  |                  | —  |                  | Cooper Thomas   |                 | Wenona Md                             |            |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]   |                  |  |                  |   |                 |                                       |            |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)   |                  |  |                  |   |                 |                                       |            |
| Myocardial infarction   |                  |  |                  |   |                 |                                       |            |
| DUE TO  |                  |  |                  |   |                 |                                       |            |
| Arteriosclerotic heart disease  |                  |  |                  |   |                 |                                       |            |
| INTERVAL BETWEEN ONSET AND DEATH<br>1 hour  |                  |  |                  |   |                 |                                       |            |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)   |                  |  |                  |   |                 |                                       |            |
| DUE TO  |                  |  |                  |   |                 |                                       |            |
| (c)   |                  |  |                  |   |                 |                                       |            |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                  |  |                  |   |                 |                                       |            |
| Hypertensive cardiovascular disease, chronic gall bladder disease   |                  |  |                  |   |                 |                                       |            |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                  |  |                  |   |                 |                                       |            |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                  |   |                 |                                       |            |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19   |                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |                 | 20f. (City or town) (County) (State)  |            |
|   |                  |  |                  |   |                 |                                       |            |
| 21. I certify that I attended the deceased from April 3, 1958, to April 3, 1958, that I last saw the deceased alive on April 3, 1958, and that death occurred at 6pm M, from the causes and on the date stated above. |                  |  |                  |   |                 |                                       |            |
| ADDRESS (Street, city or town, state) DATE SIGNED   |                  |  |                  |   |                 |                                       |            |
| ACTUAL SIGNATURE Everett C. Sutter M.D. Dames Quarter, Maryland 4-5-58  |                  |  |                  |   |                 |                                       |            |
| PHYSICIAN'S NAME (Type) Everett C. Sutter MD  |                  |  |                  |   |                 |                                       |            |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |                  | 22b. DATE THEREOF  |                  | 22c. NAME OF CEMETERY OR Crematory  |                 | 22d. LOCATION (City, town, or county) |            |
| Burial  |                  | 4-6-58   |                  | St. Paul's  |                 | Wenona Md                             |            |
| 23. FUNERAL DIRECTOR'S SIGNATURE  |                  | ADDRESS  |                  | 24a. REC'D. BY REGISTRAR  |                 | 24b. REGISTRAR'S SIGNATURE            |            |
| Webster   |                  | Deaf Island Rd   |                  | APR 10 '58  |                 | Altough                               |            |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU N.Y.

22 OCT 1958

EDISON

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5703 CERTIFICATE OF DEATH

04997

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |                                  |   |  |  |   |   |   |   |   |   |  |
|---|----------------------------------|---|--|--|---|---|---|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Somerset</b>   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> |   |   |   |   |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crisfield</b>  |                                  |   |  | c. LENGTH OF STAY IN 1b<br><b>Lifetime</b>   |   |   |   |   |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>R.F.D. # 1</b>   |                                  |   |  | e. STREET ADDRESS<br><b>R.F.D. # 1</b>   |   |   |   |   |   |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>FANNIE</b>   |                                  |   |  | First<br><b>H.</b>   | Middle<br><b>WARD</b>   | Last<br><b></b>   | 4. DATE OF DEATH<br>Month<br><b>April</b> Day<br><b>20</b> Year<br><b>19 58</b> |   |   |   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 18, 1867</b>  |   | 9. AGE (In years lost birthday)<br><b>90 yrs.</b>                                 | 10. IF UNDER 1 YEAR<br>Months<br><b></b>  | 11. IF UNDER 24 HRS<br>Days<br><b></b>  | 12. IF UNDER 24 HRS<br>Hours<br><b></b> | 13. CITIZEN OF WHAT COUNTRY<br><b>U S A</b> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Domestic</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Crisfield, Md.</b>                |   |   |   |   |  |
| 13. FATHER'S NAME<br><b>Edgar W. Horsey</b>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary E. Hickman</b>   |   |   |   |   |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>  |                                  |   |  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |   | 17. INFORMANT<br><b>Miss Kathryn Ward--R.F.D.#1-Crisfield, Md.</b>                |   | Address<br><b></b>  |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>Cerebral Atherosclerosis</b><br>DUE TO<br><b>5 yrs.</b>   |                                  |   |  |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH  |   |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>DUE TO<br>(c)  |                                  |   |  |  |   |   |   |   |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Pneumonia</b>  |                                  |   |  |  |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b></b>  |                                  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)<br><b></b>               |   |   |   |   |   |   |  |
| 20c. TIME OF INJURY<br>Hour a. m.<br>p. m.<br><b>19</b>   |                                  | Month<br><b></b>  | Day<br><b></b>   | Year<br><b></b>  | 20d. INJURY OCCURRED<br>White<br>Not white<br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b></b> | 20f. (City or town)<br><b></b>  | (County)<br><b></b>   | (State)<br><b></b>                      |   |  |
| 21. I certify that I attended the deceased from <b>April 11, 1958</b> to <b>April 20, 1958</b> , that I last saw the deceased alive on <b>April 19, 1958</b> , and that death occurred at <b>4:00A.M.</b> from the causes and on the date stated above. |                                  |   |  |  |   |   |   |   |   |   | ADDRESS (Street, city or town, state)<br><b></b> |
| ACTUAL SIGNATURE<br><b>Sarah M. Peyton</b> M.D.   |                                  |   |  |  |   |   |   |   |   |   | DATE SIGNED<br><b></b>                           |
| PHYSICIAN'S NAME (Type)<br><b>Dr. Sarah M. Peyton, M. D.</b>  |                                  |   |  | Main St.--Crisfield, Md.   |   |   |   |   |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>April 22, 1958</b>  |  | 22c. NAME OF CEMETERY OR CREMATORIUM<br><b>Sunnyridge Cemetery</b>   |   | 22d. LOCATION (City, town, or county)<br><b>Crisfield, Md.</b>                    |   | (State)   |   |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Bradshaw &amp; Sons--Crisfield, Md.</b>  |                                  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>APR 24 '58</b>  |   |   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Allred</b>   |   |   |  |

BUREAU Y. S

APR 24 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4991

## CERTIFICATE OF DEATH

04998

Reg. Dist. No.

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Somerset</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crisfield</b>  |  | c. LENGTH OF STAY IN 1b<br><b>9 years</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>S. First St.</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>GERTRUDE</b>   |  | First<br><b>ANN</b>  | Middle<br><b>WEBB</b>   |
| 4. DATE OF DEATH<br><b>April 17,</b>  |  | Month<br><b>Month</b>  | Doy<br><b>Day</b>   |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH<br><b>June 10, 1891</b>  |  | 9. AGE (In years<br>(last bithday)<br><b>60 yrs.</b>   | IF UNDER 1 YEAR<br>Months<br><b>Days</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>Heathville, Virginia</b>  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 13. FATHER'S NAME<br><b>Charles H. Clark</b>   |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Mary Ann Dungan</b>  |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>No</b>                     |   |
| 16. SOCIAL SECURITY NO.<br><b>None</b>  |  | 17. INFORMANT<br><b>Lloyd A. Webb, S. 1st St., Crisfield, Md.</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>Cerebral hemorrhage</b>  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b>   |   |
| DUE TO<br>Conditions, if any, which<br>give rise to immediate<br>cause (a), stating the under-<br>lying cause last.<br>(b)<br>DUE TO<br><b>Hypertensive arterio-sclerotic heart</b><br>disease  |  | (c)  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                               |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)                          |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m.<br>p. m.<br><b>19</b>  |  | 20d. INJURY OCCURRED<br>White of work <input type="checkbox"/> Not white at work <input type="checkbox"/>            |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town)<br>(County) (State)  |   |
| 21. I certify that I attended the deceased from <b>Nov</b> , 19 <b>57</b> , to <b>Jan</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Jan 30</b> , 19 <b>58</b> , and that death occurred at <b>445 rd</b> M, from the causes and on the date stated above. |  | ADDRESS (Street, city or town, state)<br><b>Crisfield Md</b>   |   |
| ACTUAL SIGNATURE<br><b>C. G. Rawley</b>   |  | DATE SIGNED<br><b>4-20-58</b>  |   |
| PHYSICIAN'S NAME (Type)<br><b>C. G. Rawley, M. D.</b>   |  | Crisfield, Md.   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>4-20-58</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORIUM<br><b>Webb-Clark Private Cemetery</b>  |  | 22d. LOCATION (City, town, or county)<br><b>Heathville, Virginia</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Bradshaw &amp; Sons, Crisfield, Md.</b>  |  | 24a. REC'D BY REGISTRAR<br><b>PR 2 2 '58</b>   |   |
|   |  | 24b. REGISTRAR'S SIGNATURE<br><b>DeLoach</b>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. S.  
RECEIVED

APR 22 1963

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**5004 CERTIFICATE OF DEATH**

04999

Reg. Dist. No.

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>SOMERSET</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b> |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CRISEFIELD</b>  |                                  | c. LENGTH OF STAY IN lb<br><b>2 DAYS</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>EDW. W. MCCREADY MEMO. HOSP.</b>  |                                  | e. STREET ADDRESS<br><b>X FAIRMOUNT</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br><b>GEORGE</b>   |                                  | 4. DATE OF DEATH<br><b>APRIL 24 1958</b>   | Month Day Year                                |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                                | 8. DATE OF BIRTH<br><b>8-12-1897</b>          |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CARPENTER</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>OHIO</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>JAMES WHALEN</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>JOHANNA RYAN</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>no   |                                  | 16. SOCIAL SECURITY NO.<br><b>301-09-4657</b>  |   |
| 17. INFORMANT<br><b>OMA WHALEN, FAIRMOUNT, MARYLAND</b>  |                                  | Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |                                  | INTERVAL BETWEEN ONSET AND DEATH   |   |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>Acute Dif of Heart Disease</b><br>260 X<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Diabetes Mellitus Conv.</b><br>DUE TO<br>(c) <b>Chronic and neglectful Chronic Disease</b> |                                  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Diabetes Mellitus</b>   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                         |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. <b>K</b> 19<br>p. m.  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) _____<br>(County) _____<br>(State) _____   |   |
| 21. I certify that I attended the deceased from <b>Aprl 22, 1958</b> to <b>Aprl 24, 1958</b> , that I last saw the deceased alive on <b>APRIL 24, 1958</b> , and that death occurred at <b>4:40 AM</b> , from the causes and on the date stated above.   |                                  | ADDRESS (Street, city or town, state)<br><b>MARION STATION, MD.</b> DATE SIGNED<br><b>4/24/58</b>                    |   |
| ACTUAL SIGNATURE<br><b>George C. Coulbourn</b>   |                                  | M.D.   |   |
| PHYSICIAN'S NAME (Type)<br><b>GEORGE C. COULBOURN, M.D.</b>  |                                  | MARION STATION, MARYLAND   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>   |                                  | 22b. DATE THEREOF<br><b>4-28-1958</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORIUM<br><b>Evergreen Cemetery</b>  |                                  | 22d. LOCATION (City, town, or county)<br><b>Waverly, Ohio</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Lewis B. Wilson</b>   |                                  | ADDRESS<br><b>Princess Anne, Maryland</b>  |   |
|  |                                  | 24a. REC'D BY REGISTRAR<br><b>APR 29 1958</b>  | 24b. REGISTRAR'S SIGNATURE<br><b>Debrauch</b> |

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APR 29 1958

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 11/11/09 BY SP/SP

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05000

## 5705 CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                    |   |  |
|--|------------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>SOMERSET</b>  |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>PRINCESS ANNE</b>   |                                    | b. COUNTY<br><b>SOMERSET</b>  |  |
| c. LENGTH OF STAY IN 1b<br><b>LIFE TIME</b>  |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>PRINCESS ANNE</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION  |                                    | d. STREET ADDRESS   |  |
| e. IS RESIDENCE<br>ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                    |   |  |
| 3. NAME OF<br>DECEASED<br>(Type or print)  | First<br><b>SARAH</b>              | Middle<br><b>WHITE</b>  | 4. DATE<br>OF<br>DEATH<br><b>4 6 1958</b>                    |
| 5. SEX<br><b>FEMALE</b>  | 6. COLOR OR RACE<br><b>COLORED</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6/10/1870</b>                         |
| 9. AGE (In years<br>last birthday)<br><b>87 yrs.</b>   |                                    | 10. IF UNDER 1 YEAR<br>Months<br><b>0</b>   | 11. IF UNDER 24 HRS.<br>Days<br><b>0</b>                     |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><b>HOUSE WORK</b>  |                                    | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>HOUSE WORK</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b> |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                    | 13. FATHER'S NAME<br><b>WILLIAM H. HAYMAN</b>   |  |
| 14. MOTHER'S MAIDEN NAME<br><b>CHARLOTTE WINDER</b>  |                                    | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  |
| 16. SOCIAL SECURITY NO.<br><b>111-11-1111</b>  |                                    | 17. INFORMANT<br><b>LOTTIE WINDWRIGHT PRINCESS ANNE, MD.</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>331X</b><br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause last. }<br>(b) DUE TO<br>DUE TO<br>(c) DUE TO   |                                    | INTERVAL BETWEEN<br>ONSET AND DEATH<br><b>6 days</b><br><b>6 months</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Cerebral Haemorrhage</b><br><b>Hypertension</b>  |                                    |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m.      p. m.<br>19  |                                    | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                    | 20f. (City or town)<br>(County) (State)   |  |
| 21. I certify that I attended the deceased from <b>April 3, 1958</b> to <b>April 5, 1958</b> , that I last saw the deceased alive on <b>April 3, 1958</b> , and that death occurred at <b>12:45 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state)<br><b>Elton G. Markman</b><br><b>Princess Anne, MD</b> |                                    |   |  |
| DATE SIGNED<br><b>Elton G. Markman</b>   |                                    |   |  |
| ACTUAL<br>SIGNATURE  |                                    | PHYSICIAN'S<br>NAME (Type)<br><b>ELDON G. MARKMAN</b>   |  |
| 22a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>BURIAL</b>  |                                    | 22b. DATE THEREOF<br><b>4/10/58</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORIUM<br><b>JOHN WESLEY</b>   |                                    | 22d. LOCATION (City, town, or county)<br>(State)<br><b>PRINCESS ANNE, MARYLAND</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Walgrave &amp; Jones Jr. Princess Anne, MD</b>  |                                    | 24a. ADDRESS<br><b>ADDRESS</b>  |  |
| 24b. REC'D BY REGISTRAR<br>DATE<br><b>APR 10 '58</b>   |                                    | 24c. REGISTRAR'S SIGNATURE<br><b>Aut. each</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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